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Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you today to discuss the President's proposed 2005 budget for the Department of Health and Human Services. My name is Alan Weil and I direct the Assessing the New Federalism project at the Urban Institute, a non-profit, non-partisan research institute in Washington, D.C. Before coming to the Urban Institute I was executive director of the Colorado Department of Health Care Policy and Financing, which is the state Medicaid agency.

While the HHS budget covers many topics, I will focus on how it will affect Americans' health insurance coverage. Last month, the Institute of Medicine (IOM), which, as part of the National Academy of Sciences, has a charter granted by Congress to advise the federal government on scientific matters, released a report calling for universal health insurance coverage in America by 2010. The report, which was the culmination of three years of study, documented the huge cost to the nation, to communities, to families and individuals for leaving this problem unaddressed. It called for leadership from Congress and the Administration to achieve the goal of universal coverage. Knowing that solving this problem would take some time, the IOM also recommended that existing sources of public insurance coverage be maintained so the problem does not get even worse in the interim. And the report reminded us that there are 43 million Americans without health insurance – a figure that has grown by 3 million in the last three years.

Unfortunately, the proposed 2005 budget fails to provide the leadership the nation needs in addressing the problem of the uninsured, and it fails to protect the existing coverage most Americans have. This budget represents a step backwards when it comes to one of America's most important challenges: covering the uninsured.

There are three ways of considering how the President's budget will affect the uninsured. First, the budget includes a few proposals specifically designed to address this topic. Second, the budget includes a number of provisions that affect Medicaid, which is the cornerstone of coverage for low-income Americans who would almost certainly be without insurance coverage if they did not have Medicaid. Third, the budget affects the costs and funds states have available to meet their residents' health care needs. I examine each of these areas in turn to reach some overall conclusions regarding the effects of the budget on the uninsured.

Proposals for the Uninsured

The President's budget proposes three policies specifically targeted at the uninsured.

First, the President "proposes" a modest tax credit for low-income individuals and families that purchase health insurance in the individual market – that is, who buy it on their own and do not receive it through their employer. I put "proposes" in quotation marks because the budget does not include funding for this measure. This makes it difficult to take the proposal seriously, since the Administration can only advocate for these provisions if they identify offsetting savings – something they have thus far declined to do.

Appropriately designed tax credits could play a constructive role if they were introduced as part of a comprehensive effort to provide health insurance to all Americans and they were used in conjunction with expansions of public coverage for low-income people.

However, in the President's budget tax credits stand alone and therefore must be judged alone for their ability to meet the needs of the uninsured. Many people have written about the shortcomings of tax credits as an approach for reducing the number of people without health insurance. Tax credits suffer from five problems—problems of availability, adequacy, amount, administration and accountability.

Availability. The most serious problem with tax credits is that of availability. Most tax credit proposals, such as the one offered by President Bush, are designed to encourage people to purchase coverage in the individual health insurance market. Insurers in this market routinely deny coverage to those with any identifiable health problems, or they write coverage that excludes conditions or body systems where there is any history of medical problems. When coverage is offered, rates are many times higher for older adults than for those who are younger. Administrative costs routinely exceed 30 percent of the premium. Given the current state of the non-group market, health insurance simply will not be available to those who most need it, regardless of the size of a tax credit.

Adequacy. The second problem with tax credits is that of adequacy. The size of the credit—$1000 for an individual and $2000 to $3000 for a family in the President's proposal—falls far short of the cost of health insurance. Since few families of modest means can or will pay the difference between the credit and the cost of a typical health insurance plan, newly-insured tax credit users will primarily end up in plans with deductibles and copayments that run in the thousands of dollars, with many excluded services or significant limitations on coverage. These limited benefit packages will leave families in exactly the position they find themselves today: deferring needed care because of cost, at risk of bankruptcy if they get sick, and placing a tremendous financial burden of uncompensated care on the entire health care system.

Amount. The third problem with tax credits is that of the amount. Tax credits suffer from what I call the goldilocks problem. That is, a credit that is large enough to entice a significant number of people to buy health insurance in the individual market is also large enough to cause serious disruption in the employer market, thereby jeopardizing coverage for a much larger number of people. A credit that is small enough to avoid harming the employer market is too small to help very many of the uninsured. Most tax credit proposals seek the middle ground, but there is no such thing as a tax credit that is "just right."

Another often-ignored problem with setting the amount of the credit is how it will interact with existing or potential state policy choices with respect to public coverage through Medicaid and/or SCHIP. The presence of a tax credit large enough to help an individual purchase coverage will also reduce the incentives states have to retain or expand optional coverage in public programs that require the state to pay a portion of the bill. Faced with the choice between a fully federally-funded tax credit or a matching Medicaid or SCHIP program, states have a clear incentive to rely upon the former. This scaling back of state effort would yield fewer people with comprehensive insurance coverage and a larger fiscal burden for the federal government.

In short, it is impossible to set a credit amount that strikes some theoretically correct balance between helping no one and undermining the existing public and private health insurance system.

Administration. The fourth problem with tax credits is that of administration. At a minimum, a tax credit must be refundable and paid in advance if it is to help a working family purchase coverage. Unfortunately, even with these provisions many families will be unaware of the credit, fail to take advantage of it, or not take it in advance because they will worry they will have to pay the government back if they receive a small wage increase during the year.

Problems of administration arise in part from the desire to use the tax system to effect a goal that is inconsistent with its primary purpose. Although recent provisions, such as the EITC and the child care credit, have included similar features of refundability, neither of those credits involves the same complexity as that of the proposed health insurance tax credit. For example, eligibility for the health insurance credit is based upon the absence of something else—employer sponsored insurance and public insurance—which must be verified. Health insurance is bought by family units that do not necessarily align with tax filing units. The tax code is very good for changing marginal incentives but it is an awkward tool at best for achieving health insurance coverage.

Accountability. The fifth problem with tax credits is that of accountability. Most people rely upon their employer or a public agency to provide them information about their health plan, assist with problems, and monitor the quality of coverage. But people in the individual market are on their own. If their coverage is cut, their premiums rise, or there is a dispute over their benefits, they must fend for themselves. If the federal government is providing financial incentives to purchase coverage, individuals will expect the federal government to address these problems. Consumer outcry among those who are denied coverage or who feel mistreated by their health plan will create immense pressure for the federal government to do something.

Overall, the President's proposed tax credits will only help a very small number of people purchase health insurance, are inefficient as a matter of health policy because they will mostly be used by people who already have coverage, and they put at risk the coverage many people now have through their employment.

The President's second proposal is to provide a tax deduction for the premiums people pay for catastrophic health insurance purchased in conjunction with the establishment of a Health Savings Account (HSA). This proposal offers no new coverage for the uninsured and threatens to increase costs for people most in need of coverage.

It can be debated whether HSAs will achieve their stated goal of turning patients into price-sensitive, value-seeking consumers. What cannot be debated is that every person who gives up comprehensive health insurance coverage and shifts to catastrophic coverage is moving from a broader risk pool to a narrower one. It can be debated whether HSAs are only a good deal for healthy people. What cannot be debated is that HSAs are a better deal for healthy people than they are for sick people, and they are a better deal for wealthy people than they are for poor people. Inherent in the HSA approach is the tendency to divide the health insurance risk pool between high and low risks and between rich and poor. While the extent to which this division will occur can be debated, the tendency for it to occur cannot.

The only possible consequence of providing a tax subsidy for the purchase of catastrophic coverage is to even further skew the benefits of HSAs to the rich. After all,

a tax deduction offers the most value to people with the highest incomes, and is of little or no value to the typical person without health insurance.

Thus, at best, the budget proposal helps the wealthiest Americans while doing nothing for the uninsured. But at worst, the proposal increases the incentive for healthy people to leave the broader risk pool, thereby increasing premiums for everyone else, and making it harder for employers to continue providing coverage to their employees. This is a step in the wrong direction when it comes to addressing the needs of the uninsured.

While not actually in the budget, the President also proposes to permit the formation of Association Health Plans that can purchase insurance coverage for a group while being exempt from state insurance regulations. The best thing that can be said about this proposal is that it does not cost any money. However, this proposal shares the fundamental weaknesses of the other two proposals in the budget: it encourages fragmentation of the risk pool and it does nothing to address the fundamental reason so many people are without health insurance, which is cost.

In sum, the three proposals related to health insurance coverage represent a flawed and ineffective set of approaches to reducing the number of Americans without health insurance. All three fragment the risk pool, which means that, to the extent anyone benefits from the proposals, the benefits will flow to people who are healthy and not to those with the greatest need. Two of the three rely upon changes in the tax code to encourage individuals to change their behavior, which has a failed track record in the area of health insurance. And the only one of the three that is funded directs its funds to higher income people.

Most disappointing is that elsewhere in the budget the President touts the success of the State Children's Health Insurance Program (SCHIP). While SCHIP has its limitations, it does provide a comprehensive set of benefits to the neediest children and it does not discriminate against those who are sick. Given the choice between building upon programs like Medicaid and SCHIP that have a proven track record of providing access to health care services to needy Americans, and experimenting on the poor with new theories like tax credits and tax-preferred savings accounts, this budget reflects the wrong choice.

Medicaid Proposals

In order to understand the implications of the President's budget on the uninsured, it is also important to examine how the budget affects the Medicaid program. Medicaid is the cornerstone of the nation's policy on covering the poor, reaching 50.7 million people.

The President proposes a handful of changes in the Medicaid program, many of which are small, but positive steps for the program. However, there are two large proposals that would have more substantial effects on the program.

The budget proposes changes designed to limit a series of strategies states have used to obtain federal matching funds. The overall goal of improving Medicaid's fiscal integrity is a worthy one. However, this initiative has two shortcomings.

First, barriers to state financing schemes can also impose undue barriers to legitimate state efforts to finance their programs. At a time when state resources are particularly

tight, states can ill afford to have the federal government block their appropriate efforts to preserve the funding they need to administer their Medicaid programs.

Second, this initiative, if successful, will remove funds from the Medicaid program at a time when the needs of that program are growing. The President's budget does not propose to plow the savings this initiative generates back into the Medicaid program or into other efforts to meet the health care needs of low-income people.

The President's budget also indicates a continued interest in converting the entire Medicaid program into a block grant, although specific provisions to make this change do not appear in the budget. The nation's governors were right to reject this risky and destructive proposal last year. Another year's time having passed does not make this proposal any better.

Many people have written about the damage Medicaid block grants will cause to the millions of low-income people who currently are enrolled in the program, and to the longer-term fiscal circumstances of the states. In a paper I wrote with my colleague John Holahan we discuss four reasons block grants for Medicaid are a bad idea: they represent a misdiagnosis of the problems facing Medicaid, the flexibility they create is unlikely to generate substantial savings, they shift risk to a level of government less able to bear it, and they lock in existing inequities.

Misdiagnosis. Medicaid is an efficient program. While the program is expensive, this is primarily because of the population it serves. As the President's budget shows, 69 percent of Medicaid spending is attributable to people with disabilities and the elderly – groups for whom private health insurance is not a realistic option. When comparing similar populations, Medicaid costs per person are actually lower than those for private insurance. Thus, the premise of the block grant proposal – that Medicaid is inefficient and block grants would make it efficient – is flawed.

Flexibility does not provide fiscal relief. Our analysis shows that scaling back optional benefits and increasing cost sharing will not generate substantial savings. Under current law states can eliminate certain categories of eligibility and tighten eligibility standards. Even in tough fiscal times states hesitate to take these actions because they know that the Medicaid population has no other alternatives. Block grants would give states the new option of creating waiting lists, but there is little reason to believe states would find this more appealing than the unpleasant options already available to them under current law.

Shifting risk. The primary effect of a Medicaid block grant is to shift the financial risk of meeting the health care needs of the poorest and most disabled Americans to the states. State revenues are more volatile than those of the federal government, their tax bases are narrower, and they cannot run deficits. In tight times states are likely to shift these risks to local governments and even to individual enrollees. A health care safety net based on state and local financing is less stable than one that assures federal financial participation when new needs arise.

Inequities. The current distribution of federal funding to states is inequitable when considering traditional measures such as poverty rates or the number of people without health insurance. While states' historical choices are responsible for many of these inequities, under current law states that shift direction and cover a new population or

service can gain new matching funds. Block grants lock in existing inequities, preventing states that have provided less coverage in the past from being able to draw down additional federal funds in the future even if they wish to invest in new solutions to their health care problems.

I conclude that Medicaid block grants would have the ironic effect of reducing creativity and innovation at the state level. Why? Because money is necessary for states to initiate real innovations, and the block grant structure, by shifting costs and risks to the states, will make states more conservative in their behavior.

The President's budget does reintroduce a number of proposals made in prior years to strengthen the Medicaid program, and these deserve your support. However, a simple calculation demonstrates how limited these proposals are. Setting aside the continuation of expiring programs, the budget for 2005 includes $182 million for new initiatives in Medicaid, while it makes cuts of $1.9 billion. Thus, on net, this is a budget that scales back support for Medicaid, which is a step in the wrong direction if our goal is to preserve the coverage people currently have.

Resources for State Health Programs

The final aspect of the President's budget that will affect the plight of the uninsured is proposals that affect state spending and resources for health care overall. Each year states make key decisions regarding coverage levels in Medicaid and other programs that aid the uninsured. If the federal government shifts health costs to the states or fails to support the programs it has created, states are left with less money to meet these health care needs. The budget leaves states with inadequate resources in two areas.

The new Medicare prescription drug law imposed new costs on states. States face new administrative responsibilities and will undoubtedly see higher levels of enrollment in the Medicare Savings Plans (what were formerly called Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries). These new responsibilities and enrollees bring with them additional costs. While a well-designed prescription drug benefit could provide fiscal relief to states by reducing the share of drugs states pay for through their Medicaid programs, the law as enacted seeks to recover most of these savings. States face substantial budgetary uncertainty due to the so-called "claw back" provisions.

Meanwhile, the new Medicare law fails to reflect many of the lessons states learned by implementing prescription drug programs in the years before the federal government took action. States learned that administrative simplicity in eligibility standards and benefit design was an essential component of a successful plan. States learned that they had to take an active role in reducing prescription drug costs and not simply rely upon others to achieve savings. The new Medicare drug program creates new gaps and complexities for some Medicaid beneficiaries because it does not mesh well with existing Medicaid policies with respect to cost sharing and formularies. The new and remaining burdens states face as a result will make it harder for states to fund assistance for people without health insurance.

Last year Congress, over the objections of the President, provided fiscal relief for states, half of which came in the form of a temporary increase in the federal matching rate for

Medicaid. This funding boost came just in the nick of time and permitted many states to avert substantial cuts in their Medicaid programs.

The President's budget does not seek the continuation of these enhanced matching funds despite the fact that state fiscal conditions have barely improved from last year. The budget also allows the expiration of $1.1 billion of SCHIP money that could be allocated to states seeking to cover more children.

In total, the President's budget projects federal Medicaid spending in 2005 that is 3.4% higher than in 2004. It would be nice if this slow rate of growth reflected new efficiencies or expectations for low health care inflation. But it does not. A major reason for the low rate of growth is the expiration of the enhanced matching funds, meaning that states will be expected to bear a larger share of Medicaid costs in 2005 than they did in 2004.

While we cannot know in advance the precise effects of this shift in costs from the federal government to the states, history provides us with a guide. States will, out of necessity, scale back coverage, eliminate categories of eligibility, and freeze already-low provider payment rates thereby threatening access and quality. These are the unfortunate, but predictable, effects of this budget.

Conclusion

The Administration's budget is a statement of the President's priorities. The President periodically speaks of the need to address one of the nation's biggest problems: the large and growing number of Americans without health insurance. In evaluating this budget it is necessary to ask whether the funding decisions reflected in it will meet the nation's needs in this area.

Unfortunately, an examination of the budget makes clear that enactment of this budget would be a step in the wrong direction when it comes to the uninsured.

The budget provides no national vision of a solution to the problem. The few proposals it makes in this area offer benefits to the healthy and wealthy at the expense of the sick and the poor. These proposals threaten to undermine the base of employer-sponsored health insurance that covers the majority of Americans, and to unravel the public coverage through Medicaid that is the rope out of which the health care safety net for the poor is made.

In addition, the budget simply ignores the major role states play in preventing the uninsured problem in this country from being even worse than it is. This budget leaves states worse off than they were in 2004 while state revenues remain flat or very slowly recovering from deep troughs. While states may wield the axe of health insurance coverage cuts, this budget helps aim the blade.

Overall, this budget reflects an inadequate federal commitment to meeting the needs of Americans without health insurance coverage. I encourage your critical review of the Administration's budget for the Department of Health and Human Services so Americans can benefit from a budget that is more likely to meet their needs.

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